INDIANA CRIMINAL JUSTICE INSTITUTE
VIOLENT CRIME COMPENSATION FUND
One North Capitol Suite 1000
Indianapolis, Indiana 46204-2038
Telephone: 1-800-353-1484

In 1978, the Indiana General Assembly enacted a law which, for the first time in Indiana, provided for financial as-
sistance to victims of violent crimes.

1 The claimant must be a victim, surviving spouse or a dependent child of a victim of violent crime, including cases where there is evidence of drunk driving.
2 The crime must have occurred within the State of Indiana.
3 The crime must have been reported to police within forty eight (48) hours after its occurrence and the victim and/or claimant must cooperate with the law enforcement officials in connection with the crime.
4 The victim must have incurred a minimum of $100.00 in medical expenses as a result of the crime. Such expenses as counseling, lost income and funeral expenses may be considered after the minimum has been met. (*The maximum benefit available is $15,000.00*)
5 The victim must not have contributed to the crime.
6 Where special circumstances arise, claimants are advised to contact the Division or their attorneys for information as to eligibility.

1 The application for benefits must be filed with this agency no later than 180 days after the date crime occurred. It is necessary that the victim/claimant fill out the application and include their signature.
2 The application must be filed either in person or by mail.

3 In the event the claimant is a minor child (*under 18 years of age*), a parent or legal guardian must sign. For a minor, a certified copy of the guardianship order must be attached.
4 Send original application to the Division at the address listed above.
5 **PLEASE NOTIFY THE DIVISION OF ALL CHANGES IN NAMES, ADDRESS OR TELEPHONE NUMBER.**

For more information please contact the office at the above listed telephone

APPLICATION FOR BENEFITS FROM VIOLENT CRIMES COMPENSATION FUND

State Form 23776 (R9 / 3-97)

* This state agency is requesting disclosure of Social Security numbers that are necessary to accomplish the statutory purpose of this state agency according to IC 4-1-8.

** This information is for statistical purposes only and will not effect the eligibility of the claimant.

VICTIM INFORMATION

Name of victim *(last, first, middle initial)*			Marital status
*Social Security number	Sex ☐ Male ☐ Female	Date of birth	**Race ☐ White ☐ Black ☐ Hispanic ☐ Asian ☐ American Indian ☐ Other
Name of victim's dependents			

CLAIMANT INFORMATION

Name of claimant *(if different from the victim/last, first, middle initial)*	* Social Security number
Address of victim or claimant *(number and street)*	Work telephone number ( )
City, state, ZIP code	Home telephone number ( )
Claimant's relationship to victim	

INJURIES TO VICTIM

What injuries did the victim sustain as a result of the victimization?
Hospital for medical treatment
Address*(number and street, city, state, ZIP code)*
Name attending physician
Address *(number and street, city, state, ZIP code)*

CRIME AND PROSECUTION

Date of crime	Location of crime *(city, state, county)*
Briefly give a description of the crime	

Date and time police report was filed _____ ☐ AM ☐ PM	Name of law enforcement agency	Name of detective	Case number *(if known)*
Name of suspect (s)	Victim's relationship to suspect		

Has suspect been arrested?
☐ Yes ☐ No

Were you willing to pursue prosecution?
☐ Yes ☐ No

If "No", please explain:

Cause number *(if known)*

INSURANCE

Were the injuries you sustained covered by any of the following?

☐ Medicare ☐ Medicaid ☐ Worker's Compensation ☐ County Trustee

Medical and / or car insurance amount $ _____

Carrier(s) _____

Health Maintenance Organization carrier: _____ Coverage _____

Are you receiving any of the following as a result of the victimization:

Social Security disability $_____ Per Month

Social Security survivors benefit $_____ Per Month

Life insurance death benefits $_____ TOTAL

Were you the beneficiary ? ☐ Yes ☐ No

Worker's compensation benefits $_____ Per Week

Employer disability benefits $_____ Per Week / Month

EMPLOYMENT INFORMATION

Victim's employment name	Telephone number ( )
Address *(number and street, city, state, ZIP code)*	

RELEASE

I do hereby release the State of Indiana and the Violent Crimes Compensation Division from any and all liability which might be connected with the processing and payment of this claim. In the event the fund from which the award is paid, if the claim is allowed, is such that it is necessary to prorate the payment of the claim, I do hereby release and discharge the State of Indiana and the Violent Crimes Compensation Division from any and all liability beyond the amount actually paid to me from the fund.

SUBROGATIONS

The claimant hereby certifies that no release has been or will be given in settlement or for compromise with any third party who may be liable in damages to the claimant; and the claimant, in consideration of any payment and/or award by the Violent Crime Compensation Division in accordance with IC 5-2-6.1-22, here subrogates the State of Indiana to the extent of any such payment and/or award to any right or cause of action occurring to the claimant against any third person, and agrees to accept any such payment and/or award pursuant to the provisions of the statute. The claimant hereby authorizes the State of Indiana to sue in his/her name, but at the cost of the State of Indiana, pledging full cooperation in such action, to execute and deliver all papers and instruments, and do all things necessary to secure such right to a cause of action.

CONSENT TO PAY PROVIDERS

I do hereby consent and agree that if an award is made, money due and owing to any provider of medical services and due to any other qualified person or entity, including any attorney's fees allowed to my attorney, may be paid direct to said provider, entity or attorney by the agency and need not be paid to me.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize any hospital, physician, or other person, who attended or examined _____ any undertaker or other person who rendered services; any employers of the victim; any police or other municipal authority or agency, or public authority; any insurance company or organization, or its representative, to release any and all information with respect to the incident resulting in the victim's personal injury or death, and the claim made herewith for benefits. A photocopy of this authorization will be considered as effective and valid as the original.

I the undersigned Claimant, hereby certify under the penalties of perjury that the statements made herein are true to the best of my knowledge and belief and were made for the purpose of inducing the State of Indiana to award benefits to me for losses incurred as described above through the Violent Crime Victims Compensation Fund as prescribed in IC 5-2-6.1-40.

Signature of claimant	Date